Summary Chapter II

Mentally Healthy Youth and Young Adults

Virtually every domain in an adolescent's life has an impact on a teen's mental health. Mental health affects almost every decision an adolescent makes about behavior and is a basic element in the life of every successful teen. Adolescence is the age when serious mental health problems may emerge, the most common being depression, attention and hyperactivity disorder and bipolar (manic depressive) disorder.

Tennessee Data

In general, the availability of mental health data in Tennessee is limited to Tennessee Youth Risk Behavior Survey results and suicide-related death statistics.

Depression

- More than 28% of high school students reported they had felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities. This represents a slight increase from 1999 reports of 27.6% and matches the national rate of 28.6%.
- White youth (28.6%) were more likely to report depression than African-American youth (26.8%). Females (37.4%) were almost twice as likely to report depression as males (19.6%). White females (38.1%) are most at risk for depression closely followed by African-American females (35.5%).

Suicide

- Suicide is the third leading cause of death for Tennessee youth and young adults ages 15-24. In 2003, 86 young people ages 10-24 died from suicide. The suicide rate for teens ages 10-24 was 7.1 per 100,000 young people. The suicide rate is highest among young adults ages 20-24 (13.6 per 100,000) compared to youth ages 15-19 (6.4 per 100,000) and 10-14 (1.5 per 100,000).
- Boys complete suicide at rates approximately four times higher than girls.
- White males (13.1 per 100,000) were almost 2 times more likely to die from suicide than African-American males (7.9 per 100,000).
- In 2003, 17.5% of Tennessee students seriously considered attempting suicide, compared to 16.9% nationally.
- In 2003, 14.1% of Tennessee high school students made a suicide plan, compared to 12.8% in 1999 and 18.5% in 1993. In 2003, 17.7% were females compared to 10.6% males.
- In 2003, 28.3% of Tennessee high school students reported they had felt sad and hopeless almost every day for two weeks or more in a row that stopped them from doing some usual activities. (37.4% were female and 19.6% were male)
- According to the Tennessee Middle School Health Survey 2001-2002, which was distributed to 6th, 7th and 8th graders, 7.2% said they had attempted suicide. Also, 18.0% said they had felt desperate enough to consider suicide and 2.6% reported getting medical treatment because of a suicide attempt.

Best Practices

- *Support Mental Health Services in Primary Care and School Settings* – Research and expenditure studies indicate that most insured children with mental health issues are more likely to visit their primary care provider or pediatrician rather than a mental health specialist. Well-teen checkups seem like obvious settings to recognize and address adolescent emotional or mental health issues.
- *Promote Integrated Community Initiatives* – Programs are more likely to be successful if they are comprehensive and intensive, and designed to address suicide and suicidal behavior as part of a broader focus on mental health, coping skills in response to stress, depression, substance abuse and aggressive behaviors.
- *Establish Programs That Promote Healthy Social Skills and Relationships* – Relationships of high quality have a beneficial impact on psychological health.
- *Support Effective Treatment Approaches* – Effective approaches that work to change a person's thoughts in order to change a behavior or emotional state, drug therapy, and environmental strategies appear to reduce mental health disorders, including depression and anxiety.

2✪1✪ Objectives

Reduce Suicide Deaths

- By 2010, reduce the suicide death rate among 10-14 year olds from a 1999-2002 baseline rate of 0.76 per 100,000 to 0 per 100,000.
- By 2010, reduce the suicide death rate among 15-19 year olds from a 1999-2002 baseline rate of 8.78 per 100,000 to 6.78 per 100,000.
- By 2010, reduce the suicide death rate among 20-24 year olds from a 1999-2002 baseline rate of 12.35 per 100,000 to 10.35 per 100,000.

Reduce Depression

- By 2010, reduce the proportion of high school students who attempted suicide that required medical attention from a 2003 baseline of 3.1% to 1%.
- By 2010, reduce the proportion of high school students who were depressed for 2 weeks or more during the past 12 months from a 2003 baseline of 28.3% to 24%.

Websites

American Academy of Child and Adolescent Psychiatry
www.aacap.org

Bright Futures, Georgetown University
www.brightfutures.org

Center for Health and Health Care in Schools
www.healthinschools.org

Center for Mental Health in Schools at UCLA
www.smhp.psych.ucla.edu.

Child and Adolescent Bipolar Foundation
www.bpkids.org

Federal Interagency Forum on Child and Family Statistics
www.childstats.gov

Healthy Generations, University of Minnesota
www.epi.umn.edu/mch

Healthy People 2010
www.healthypeople.gov/

National Alliance for the Mentally Ill
www.nami.org

National Assembly on School-Based Health Care
www.nasbhc.org

National GAINS Center for People with Co-Occurring Disorders in the Justice System
www.gainsctr.com

National Institute of Mental Health
www.nimh.nih.gov

National Mental Health Association
www.nmha.org

Office of Juvenile Justice and Delinquency Prevention
www.ojjdp.ncjrs.org

Tennessee Department of Mental Health and Developmental Disabilities
http://www.state.tn.us/mental/

Tennessee Suicide Prevention Network
www.tspn.org

Urban Institute
www.urban.org

US Surgeon General
www.surgeongeneral.gov

Youth Risk Behavior Surveillance System
www.cdc.gov/nccdphp/dash/yrbs

President's New Freedom Commission on Mental Health
www.mentalhealthcommission.gov

Substance Abuse and Mental Health Services Administration
www.samhsa.gov

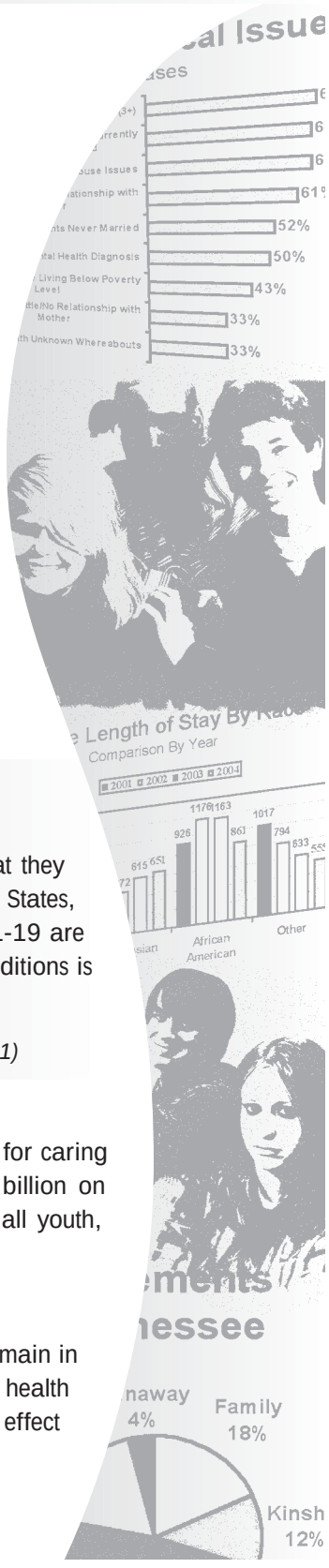
Chapter II

Mentally Healthy Youth and Young Adults

Chapter Preview

This chapter includes a description of:

- The importance of mental health in the life of an adolescent
- Mental health myths & facts
- Prevention pays
- Depression, suicide, and other mental health issues
- National and state data
- Health disparities data
- Mental health risk factors
- Best practices
- State mental health programs



Social and emotional well-being provides adolescents with a strong foundation to make healthy choices. However, experts estimate that anywhere between 10% and 15% of all children and adolescents have symptoms of a mental health disorder severe enough to cause some level of impairment.[1] These conditions can include: depression, substance abuse, post traumatic stress disorder, stress, anxiety disorders, attention deficit and hyperactivity disorder (ADHD), bipolar (manic-depressive) disorder[2] and eating disorders (anorexia, bulimia, and binge-eating).

Myths & Facts

Myth: It's just a phase.

Fact: Twenty-one percent of adolescent boys and 13% of adolescent girls report that they have "no one" to talk to when they feel stressed, overwhelmed or depressed. In the United States, emotional and behavioral problems and associated impairments among children ages 1-19 are most likely to lower their quality of life and reduce their life chances. No other set of conditions is close in the magnitude of its deleterious effects on children and youth in this age group.

Source: Children's Mental Health: A National Call to Action, U.S. Surgeon General (2001)

Prevention Pays

Poor mental health for adolescents is a costly proposition. The current estimated bill for caring for troubled youth is $12 billion annually. In 1998, Americans spent more than $1 billion on psychotropic medications (stimulants and antidepressants) to treat, on average, 4% of all youth, predominantly those aged 6-17.[3]

Mental Health Impacts Risk Behaviors

The mental health of today's teens is a real health concern, because virtually every domain in an adolescent's life has an impact on that child's mental health. Furthermore, mental health affects almost every decision an adolescent makes about behavior. Many factors have an effect on good mental health during adolescence:[4]

- Self-esteem and resilience in handling failure;
- Stability of moods, depression and suicidal ideation;

- Perceived physical appearance and weight;
- Peer support and influence;
- Several sexual health factors, including sexual development, behavior and identity; parental expectations and communication; pregnancy and HIV/ AIDS; and sexual abuse and rape;
- Family issues, including support, independence, parental expectations and limit setting, conflict and family history of mental health and substance abuse;
- Several school-related factors, including transition through grade levels, academic success, harassment and bullying, extracurricular activities, absenteeism and dropping out and transition from high school to college;
- High-risk behaviors, such as substance use, violence, firearm use and exposure to violence;
- When teens experience multiple risk factors, such as poverty, criminal behavior, violence or substance abuse, the probability of mental health problems increases;[5]
- Children in juvenile justice facilities have a very high proportion of diagnosable mental health problems (may be as high as 75-80 percent) including depression, post traumatic stress disorder, anxiety, and mood disorders;[6]
- Adolescents with learning disabilities are at greater risk of emotional distress than their peers;[7]
- Gay, lesbian, bisexual, transgender or questioning (GLBTQ) youth also are at higher risk for mental health problems and limited access to care, especially among youth of color;[8] and
- Homeless teens also suffer disproportionately from issues concerning mental health. Adolescents that are GLBTQ and homeless are even more vulnerable.[9]

Differentiating normal adolescent behaviors from serious problem behaviors can also be challenging. Involvement of qualified mental health professionals is indicated for severe or chronic disorders or violent or self-destructive behavior.

The Family Stress Index

Today's adolescents live stressful lives. A national study utilizing the Family Stress Index, defined a stressful environment as: family unable to pay mortgage, rent or utility bills; more than two persons per bedroom; food and health care insecurity; poor physical or mental health or learning disability in a parent; and/or poor physical or mental health or learning disability in a child.

This study estimated that about 22 % of American youth live in such an environment, with higher stress varying directly with lower family income level, defined as below 200 percent of federal poverty level. The research also indicated that adolescents, defined as ages 12 to 17, experiencing a stressful family environment had higher levels of behavioral and emotional problems (20 percent) than other youth (5 percent).[10]

Depression

National Data

In a national study of approximately 7,000 7th-12th graders in public school, depression affected an estimated 10% of the students.[11]

- Symptoms of depression include sadness, lethargy, disinterest in activities normally enjoyed, self-criticism, pessimism and suicidal thoughts.
- An average episode usually last from seven to nine months,[12] but 20% to 40% of children with depression experience another episode of depression within two years, and most (70%) will do so by adulthood.[13]
- Risk factors for depression include stress; loss of a parent or loved one; break-up of a romantic relationship; attentional, conduct or learning disorders: abuse or neglect; and witnessing or being personally involved in other trauma, including natural disasters. Cigarette smoking appears to be associated with teens at higher risk of developing depression.
- Younger boys and girls appear to be at equal risk for depressive disorders, but as they progress

through adolescence, girls are twice as likely as boys to develop depression.[14]

Depression, with or without alcoholism or other substance abuse problems, substantially increases the risk of suicide. More than 90% of children and adolescents who commit suicide have an identifiable mental disorder.[15]

Perhaps more than depressed adults, depressed teenagers often appear irritable, aggressive and hostile. Given that these traits are often seen in adolescents without depression, it is hardly surprising that less that one-third of adolescents with depression are actually diagnosed. The teen, his or her peers, parents, teachers or health care providers may not realize that an angry teen might have a mental health condition such as depression. Many youth do not voluntarily discuss their symptoms with adults and may choose instead to "self medicate" with drugs and alcohol.

Tennessee Data

According to the 2003 Tennessee Youth Risk Behavior Survey:

- More than 28% of high school students reported they had felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities. This matches the national rate of 28.6%.
- White youth (28.6%) were more likely to report depression than African-American youth (26.8%). Females (37.4%) were almost twice as likely to report depression as males (19.6%). White females (38.1%) are most at risk for depression closely followed by African-American females (35.5%).

Depression Among Children and Adolescents with Disabilities

According to the 2002 National Health Interview Survey, the proportion of children and adolescents with disabilities who report being sad, unhappy, or depressed has decreased in recent years to 30%. This is compared to 2003 United States Youth Risk Behavior Survey data that indicate 17% of all high school students report being sad, unhappy, or depressed. State data on this topic are not available.

Healthy People 2✪1✪ Progress

No baseline and target objectives have been developed for Objective 06-02 (reducing the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed) due to a lack of age specific data.

Suicide

National Data

Approximately 2,000 U.S. adolescents die by suicide each year; approximately two million, or about one in five, attempt suicide; and almost 700,000 receive medical attention for an attempt. More than 90 % of the adolescents who have died from suicide also suffered from an associated psychiatric disorder. More adolescent suicides are boys because they tend to use methods that are more lethal, such as firearms. However, more girls attempt suicide than boys. Again, the factors that increase youth vulnerability are often interwoven. (See Table 1)

- Suicide is the third leading cause of death among young people ages 15 to 24. In 2001, 3,971 suicides were reported in this group.
- Of the total number of suicides among ages 15 to 24 in 2001, 86% (n=3,409) were male, and 14% (n=562) were female.
- American Indian and Alaskan Natives have the highest rate of suicide in the 15 to 24 age group.
- In 2001, firearms were used in 54% of youth suicides.[16]
- Substance and/or alcohol abuse significantly increases the risk of suicide in teens aged 16 and older.
- Attempted suicide rates are higher for Hispanic youth than for white and African-American youth.

Table 1

Risk Factors for Adolescent Suicide

Personal Factors

- Sexual and physical abuse
- Alcohol and drug use and abuse
- Homosexuality
- Previous suicide attempt
- Chronic illness

Psychological Factors

- Depression
- Conduct disorder
- Bipolar disorder
- Psychosis
- Schizophrenia

Family Factors

- Firearm in home
- Low income
- History of substance abuse
- Suicide in first degree relative
- History of domestic violence
- Family conflict

Antecedent Event Factors

- Recent death of family/friend
- Romantic conflict/breakup
- Divorce/remarriage or parent
- School failure

Source: G McIntosh and M Moreno, "Fatal Injuries in adolescents, "Wisconsin Medical Journal 99(9)

Gay, lesbian, bisexual, transgender and questioning youth are at increased risk for suicide attempts. Adolescents who have experienced childhood sexual or physical abuse are also at increased risk for suicide attempts. These three groups of adolescents often have multiple risk factors.[17]

- Adolescents with learning disabilities have twice the risk of emotional distress, and females with learning disabilities are at twice the risk of attempting suicide and for being involved with violence than their peers.[18]

Prevention Pays

Based on 1996 data, researchers estimated that the cost of completed and medically treated suicides for youth (under age 20) in Tennessee was over $3 million. Medical costs alone were estimated at $19 million, future earnings lost was estimated at $56 million and quality of life losses were estimated at $234 million.[19]

Tennessee Data

Healthy People 2✪1✪ Progress

Healthy People 2010 target goals have not been established to measure the suicide rate among the adolescent/young adult age group. However, suicide is the third leading cause of death for Tennessee's adolescents and young adults ages 15-24. In 2003, 86 young people ages 10-24 died from suicide.

Healthy People 2010 Objective 18-01

Reduce the rate per 100,000 of suicide among youth ages 10-24

	Suicide Rates, Tennessee			
	1994	1999	2003	2010 Goal
Ages 10-14	0.5	1.0	1.5	NA
Ages 15-19	12.1	7.1	6.4	NA
Ages 20-24	15.8	12.6	13.6	NA
Ages 10-24	9.6	6.9	7.1	NA

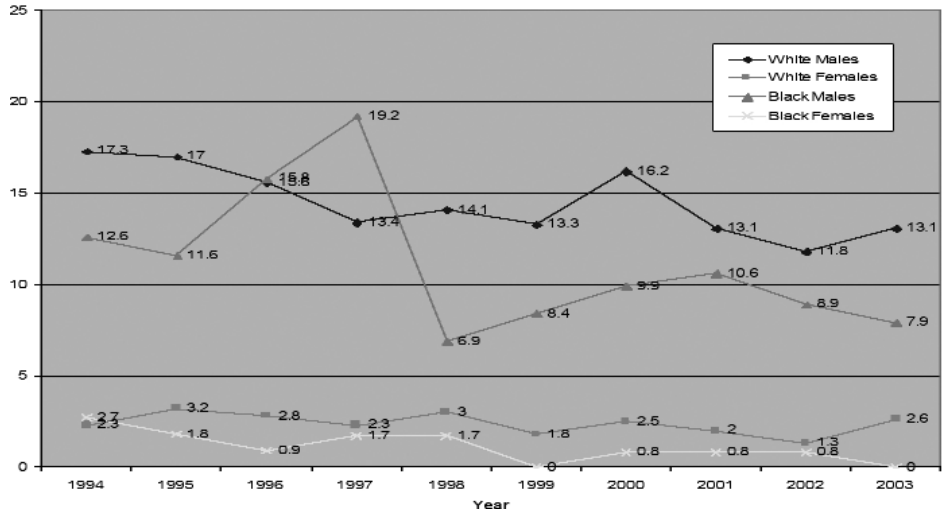
Source: Tennessee Department of Health, Death Certificate Data, 2003 Estimation Method

Health Disparities

- Males (10.5 per 100,000) were approximately 4 times more likely to die from suicide than were females (2.6 per 100,000).
- White males (13.1 per 100,000) were approximately twice more likely to die from

Table 2

1994-2003 Tennessee Resident 10 to 24 Suicides per 100,00, by Race and Sex



Source: Tennessee Department of Health, Office of Policy, Planning and Assessment, 2005

suicide than African-American males (7.9 per 100,000).

Suicide Completion

Suicide is the third leading cause of death for Tennessee's adolescents and young adults ages 15-24. There were a total of 80 suicides in 2003 among 15-24 year olds. There were six suicides in the 10-14 age group for 2003.

- The death rate due to suicides was much higher for 20-24 year olds (13.6 per 100,000), as compared to 15-19 year olds (6.4/100,000).[20]
- Males (10.5 per 100,000) were approximately four times more likely to die from suicide than were females (2.6 per 100,000). White males (13.1 per 100,000) were most at risk followed by African-American males (7.9 per 100,000) and then white females (2.6 per 100,000).
- Over the past ten years (see Table 2) the suicide rate among males, both white and African-American have declined. The rate for females has remained steady.

Attempting Suicide

Healthy People 2✪1✪ Progress

The rate of suicide attempts among high school students that required medical attention decreased substantially from 1993 to 2003. However, Tennessee still needs to reduce the rate by 2.1% in order to meet Healthy People 2010 goals.

Healthy People 2010 Objective 18-02:

Reduce the rate of suicide attempts by high school students requiring medical attention

Percent of Tennessee Students

1993	1999	2003	2010 Goal
8.3%	2.5%	3.1%	1.0%

Source: Tennessee Youth Risk Behavior Survey 1993, 1999, 2003

Health Disparity

- In 2003, African-American males (4.5%) and white females (4.2%) had twice the rate of a suicide attempt that required medical attention than white males (2%) and African-American females (1.9%).
- High school females (11.5%) were approximately twice as likely as males (6.4%) to have attempted suicide one or more times during the past 12 months.

- High School females (21.6%) were almost twice as likely to have seriously considered attempting suicide during the past 12 months compared to males (13.6%).

The Tennessee Youth Risk Behavior Survey (TN YRBS) measures the number of students that attempt suicide as well as suicide ideation, which is a statistically significant indicator of suicide attempt. Those who talk about suicide are more likely to follow through with a suicide attempt.

- In 2003, 3.1% of Tennessee high school students attempted suicide which resulted in requiring medical attention compared to 8.3% in 1993. In 2003, 3.8% were females compared to 2.5% males.
- In 2003, African-American males (4.5%) and white females (4.2%) had twice the rate of a suicide attempt that required medical attention than their white males (2%) and African-American females (1.9%) counterparts.

- In 2003, 8.9% of Tennessee high school students reported that they had attempted suicide, compared to 7.5% in 1999 and 8.6% in 1993. Females (11.5%) were almost twice as likely as males (6.4%) to have attempted suicide.
- According to the Tennessee Middle School Health Survey 2001-2002, which was distributed to 6th, 7th and 8th graders, 7.2% said they had attempted suicide. Also, 18% said they had felt desperate enough to consider suicide, and 2.6% reported getting medical treatment because of a suicide attempt.[21]

The Tennessee Youth Risk Behavior Survey (TN YRBS) self-report data listed above reflect the number of hospitalizations due to suicide attempts. According to hospital discharge data, there were 3,733 suicide attempts in 2002 among 10-24 year olds. There were only nine deaths in all of these attempts. Unfortunately, this means that the other 77 adolescent suicides were fatal prior to arrival at the hospital. The majority of the patients treated for suicide attempts were outpatient, with 876 being inpatient.

Although there was only one suicide death among 10 to 14 year olds there were a substantial number of attempts with this age group. There were 378 suicide attempts among youth ages 10 to 14, with 72 of these being inpatients. Thus the early adolescents are not to be excluded from suicide prevention.[22]

According to the Tennessee Middle School Health Survey 2001-2002, which was distributed to 6th, 7th and 8th graders, 7.2% said they had attempted suicide. Eighteen percent said they had felt desperate enough to consider suicide, and 2.6% reported getting medical treatment because of a suicide attempt.[23]

Thinking of Suicide

Even though adolescent suicide rates have been decreasing, teens are still thinking about suicide and acting upon those thoughts. According to Tennessee Youth Risk Behavior Survey (TN YRBS) data:

- In 2003, 17.5% of Tennessee students seriously considered attempting suicide, compared to 17.1% in 1999 and 24.5% in 1993. According to the 2003 TN YRBS data, 21.6% females seriously considered attempting suicide compared to 13.6% males. Nationally, 16.9% of all high school students seriously considered attempting suicide.
- In 2003, 14.1% of Tennessee high school students made a suicide plan, compared to 12.8% in 1999 and 18.5% in 1993. In 2003, 17.7% were females compared to 10.6% males.
- In 2003, 28.3% of Tennessee high school students reported they had felt sad and hopeless almost every day for two weeks or more in a row that stopped them from doing some usual activities (37.4% were female and 19.6% were male). This compares to 27.6% in 1999.

Suicide Method

In 2003, the method Tennessee adolescents and

young adults used to complete suicide ranged from using firearms (63%) followed by hanging (29%), drugs (3.6%) and other means (3.6%).[24]

Other Mental Health Issues

Bipolar Disorder

Mood swings are expected during adolescence, but when these feelings persist and interfere with daily functioning, bipolar disorder may be the cause. Bipolar disorder is a serious mental illness characterized by chronic irritability, recurrent episodes of depression, mania and/or mixed symptom states. Bipolar disorders occur in at least 1 to 2 % of the adolescent and adult population. Fortunately, bipolar disorder is treatable with medications. It is difficult to diagnose in youth, because it does not fit precisely the symptom criteria established for adults.

A word of caution is necessary: the symptoms of bipolar disorder resemble symptoms of attention deficit and hyperactivity disorder (ADHD), which is much more common. The psycho stimulant medications such as Ritalin, often prescribed for ADHD, may actually worsen the manic symptoms found in bipolar disorder.[25]

Serious Emotional Disturbance (SED)

Serious Emotional Disturbance (SED) refers to any child or adolescent under the age of 18 who has had or currently has a diagnosable, mental, behavioral or emotional disorder to meet DSM-IV diagnostic criteria. Functional impairment occurs as a result and interferes with family, school and community activities. SED excludes DSM-IV codes of substance abuse and developmental disorders unless they occur with another diagnostic DSM-IV disorder.[26]

The Tennessee Department of Mental Health and Developmental Disabilities has defined the state's prevalence rate of Serious Emotional Disturbance (SED) at 7%. This leads to an estimate of 97,969 Tennessee children 0 to 17 that have SED.[27]

Attention Deficit and Hyperactivity Disorder

Life can be hard for adolescents with attention deficit and hyperactivity disorder (ADHD). They are the ones who are often in trouble in school, are unable to finish a game and have trouble making friends. These frustrations can increase family conflict, and place the adolescent at increased risk of motor vehicle accidents, tobacco use, early pregnancy and lower educational attainment.

Attention deficit and hyperactivity disorder is an illness characterized by inattention, hyperactivity and impulsivity. Here are some know facts about ADHD:

- ADHD is the most commonly diagnosed behavior disorder in young people, affecting an estimated 3 to 5 percent of school-age children, or about one in every U.S. classroom.
- The impact of ADHD may be seriously underestimated. A study of a typical county of rural and suburban homes in North Carolina surveyed parents, and found that more that 15 percent of boys in grades one though 5 have been diagnosed with ADHD, and about 10 percent were taking medications for it.[28]
- Boys have been shown to out number girls with ADHD at a rate of about three to one.
- There are three types of ADHD, each with different symptoms: predominately inattentive, predominantly hyperactive/impulsive and combined. Girls are more likely to be identified as predominantly inattentive, whereas boys are more likely to be diagnosed as hyperactive.
- A definitive diagnosis is made when an individual displays at least six symptoms common in the disorder and clear impairment in at least two settings, such as home and school.
- ADHD is often not diagnosed until adolescence, and half of the children with the disorder retain symptoms throughout their adult lives.

- Symptoms of ADHD are often mistaken for or found occurring with other disorders. Nearly half of all children with ADHD also have oppositional defiant disorder, and conduct disorder is found to co-occur in an estimated 40 % of children with ADHD. Twenty-five percent of children with ADHD also suffer from some type of communication or learning disorder. Research is also beginning to show that ADHD-like symptoms are sometimes actually manifestations of childhood-onset bipolar disorder.[29]
- Scientific evidence supports the conclusion that ADHD is a biologically based disorder. Brain scans have observed significantly lower activity in regions of the brain controlling attention, social judgment and movement among those with ADHD than among those without the disorder.
- The most proven treatments for ADHD are medication (the most common of which is Ritalin) and behavior therapy.[30]
- Access to mental health services varies greatly among children of different racial groups. While there are no significant differences in the incidence of ADHD between Caucasian and African-American young people, African-Americans are much less likely than their Caucasian counterparts to receive psychotropic medications.[31]

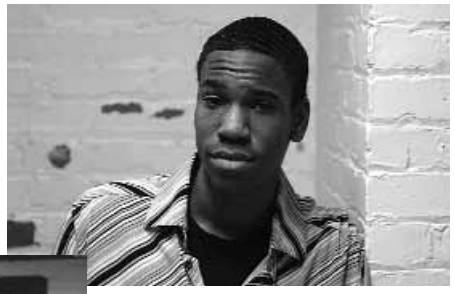
Cutting / Self-Injury…Emerging Trend

Self-injury or cutting, also called self-harm, carving, parasuicidal cutting, self-abuse and self mutilation, is the act of attempting to alter a mood state by inflicting physical harm serious enough to cause tissue damage to one's body without suicidal intent. Cutting (using some sort of sharp edge) is the most common form of self-injury, but burning or hitting oneself also are methods. The behavior is not categorized as "self-injury" if its primary purpose is sexual gratification, body decoration such as body piercing and tattooing, spiritual enlightenment via ritual or fitting in or being "cool".

Research suggests that self-injury is a coping mechanism; that is, when people who self-injure get emotionally overwhelmed, hurting themselves reduces the emotional discomfort quickly. Self-injury typically begins in adolescence, and most commonly affects teenaged girls. Experts estimate the incidence of habitual self-injurers is nearly 1% of the population, the same as that of eating disorders. However, because the practice is highly stigmatized, most hide their scars, and also have excuses ready when someone asks about the scars.[32]

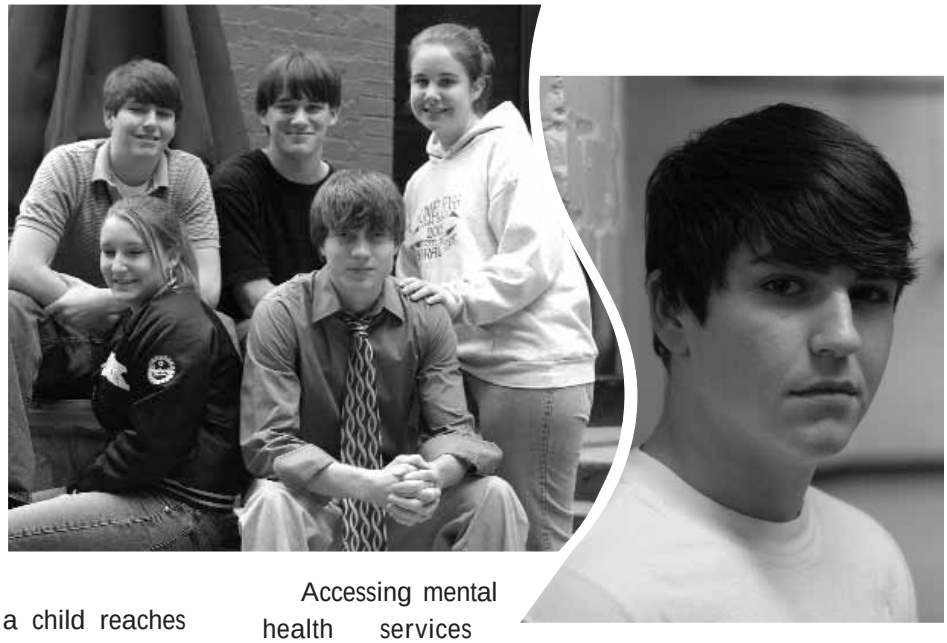
Warning signs that someone is injuring themselves include: unexplained frequent injury including cuts and burns, wearing long pants and sleeves in warm weather, low self-esteem, difficulty handling feelings, relationship problems, and poor functioning at work, school or home.

Self-injurers commonly report they feel empty inside, over or under stimulated, unable to express their feelings, lonely, not understood by others and fearful of intimate relationships and adult responsibilities. Self-injury is their way to cope with or relieve painful or hard-to-express feelings, and is generally not a suicide attempt. But relief is temporary, and a self-destructive cycle often develops without proper treatment.[33]



Eating Disorders

Eating disorders occur when people excessively overeat (binge), or binge and purge or deliberately starve themselves. Most eating disorders begin in childhood or adolescence. Eating disorders primarily affect adolescent girls (90%). Eating disorders occur in one to three percent of the adolescent female population. Researchers have concentrated on four areas when trying to determine the causes of eating disorders; personality traits, biochemistry, genetics, and environment.



- Anorexia usually begins when a child reaches puberty and involves extreme weight loss, at least 15% below an average body weight. Young persons with this disorder typically starve themselves, even though they may feel intense hunger pains. Sometimes the young person must be hospitalized to prevent starvation.
- Bulimia occurs when an adolescent has repeated episodes of bingeing and purging. Because persons with bulimia binge and purge in secret and usually maintain a normal body weight, they can hide this disease from others for years.
- Binge eating disorder is like bulimia where the adolescent overeats. However, they do not purge their bodies of excess food. Most young people with this disorder are obese.[34]

Access to Mental Health Services

According to a recent report, the U.S. mental health system is in crisis, "unable to provide even the most basic services and supports".[35] The unmet needs and barriers to mental health care that are common in the United States are exacerbated for children. According to the President's New Freedom Commission on Mental Health, the "mental health maze is even more complex and inadequate for children" than it is for adults. While there are more programs set up to serve children, the commission concluded, they are supported with uncoordinated funding streams and differing eligibility requirements. Frequently, eligibility is cut off after age 18, when many disturbed youth need additional support to move toward emancipation.[36]

Accessing mental health services before a crisis is obviously a "best practice" for prevention. The primary consequence of not receiving care early enough is often a spiraling cycle of missed opportunities and poor outcomes. On average, only one-fourth of children who need mental health care get the help they need.[37] Certain youth populations suffer disproportionately. National researchers estimate that Hispanic and African-American adolescents have the highest rates of need for mental health services, and that Hispanic teens are the least likely of all teens to access mental health care.[38]

Privately-funded care often falls short of covering all necessary treatments, and out-of-pocket services are costly. Fortunately, publicly-funded services such as TennCare are available to help many children in need. Still, certain Medicaid-related services and options are not used as effectively as they might be. In particular, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Home and Community-Based Services (HCBS) waivers, and the Tax Equity and Financial Responsibility Act (TEFRA) option are under-utilized. This is primarily because states are unfamiliar with or misinformed about the available options, or are concerned about costs associated with implementation.

Not taking full advantage of available options is costly. States end up paying for the treatment and care of children with mental illnesses one way or another—either when it is first needed and most effective; through other systems (such as juvenile justice); or later in life when other problems manifest. The burden on families is significant. In fact, some parents relinquish custody of

children in order to get care. Other families are "spending down" assets, quitting jobs, and getting divorced in order to reduce their finances so that they become eligible for Medicaid and, in turn, receive adequate mental health benefits for their children. To help eliminate these drastic alternatives and ensure care, states can expand coverage of children with mental illnesses by:

- effectively implementing EPSDT requirements;
- adopting either HCBS waivers or the TEFRA option;
- expanding existing TEFRA options in states where children with mental health disorders currently do not qualify; and
- considering adoption of mental health parity provisions and exploring both the costs and savings associated with doing so.[39]

Best Practices for Mental Health

Best practices are those strategies, activities or approaches that have been shown through research and evaluation to be effective at preventing and/or delaying a risky/undesired health behavior or conversely, supporting and encouraging a healthy/desired behavior.

Assure Early Access to Mental Health Services

"Emergency Response: A Roadmap for Federal Action on America's Mental Health Crisis" is a coalition of 16 national organizations' proposed 28 action steps for Congress and the Administration to transform the country's ailing mental health care system. Among the 28 action items included in the Roadmap report are proposals by the Campaign to:

- End discrimination by health insurance plans through enactment of mental health parity legislation this year;
- Better utilize Medicaid dollars by providing cost-effective home- and community-based care in lieu of institutional care, and permitting states to utilize Medicaid dollars for comprehensive treatment plans;
- Allow families to buy into Medicaid to access services for a child with a disability;
- End the unconscionable and costly "warehousing" of youth with mental disorders;
- End discrimination against mental health treatment in Medicare, which requires higher co-payments for mental health outpatient care and limits inpatient hospital coverage for mental health treatment; and
- Provide early detection and intervention services to mothers and children who receive health care at federally funded maternal and child health clinics.

The President's New Freedom Commission on Mental Health report states that about 20 years ago it became clear that children and families were failing to receive adequate mental health care from the public sector, whose services were fragmented, inadequate, and over-reliant on institutional care. As a result, the emphasis of service delivery has now shifted to systems of care that are designed to provide culturally competent, coordinated services; community-based services; new financing arrangements in the private and public sectors; family participation in decision-making about care for their children; and individualized care drawing on treatment and social supports called wraparound services.

Increase Mental Health Services In Primary Care and School Settings

Research and expenditure studies indicate that most insured children with mental health issues are more likely to visit their primary care provider or pediatrician rather that a mental health specialist. Well-teen checkups seem like obvious settings to recognize and address adolescent emotional or mental health issues. In some health care delivery settings, the limited duration of the average visit spent with a provider, between 11 and 15 minutes, poses a barrier.[40]

The President's New Freedom Commission on Mental Health identified model programs that might be replicated, including school-based programs that offer accessibility, reduce the stigma of mental illness that is common in American culture and provide the opportunity for melding school district and mental health funds. "Wraparound" programs were also identified as a promising approach; these programs strive to integrate services and funding for the most seriously affected adolescents at a single site to improve access.[41]

School often serves as the de facto mental health system for school-age children and youth. Research

indicates that of those adolescents who receive care, most (70-80 percent) receive that care in a school setting. Schools employ a variety of means to provide these services:

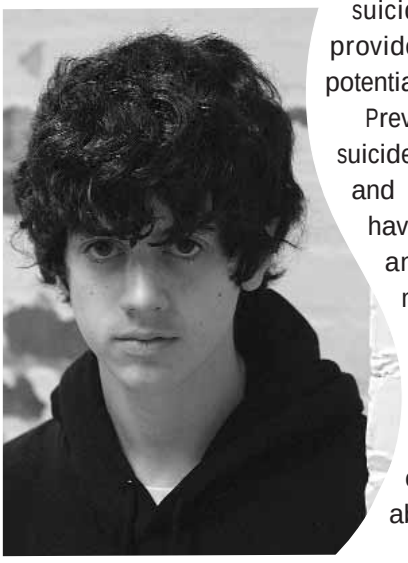
- School-financed services, including school nurse, school psychologist, social workers;
- School health unit, including school-based or linked health center, wraparound services and formal linkages between schools and community mental health providers; and/or
- Classroom-based curriculum and counseling provided at school.

School-based health centers have been shown to have an impact on school measures of success. In one study, students served by the centers in Dallas, Texas, had fewer discipline problems, course failures and school absences.[42]

The U.S. Surgeon General's reports in 1999 and 2001 on children's mental health identify schools as major settings for addressing the mental health needs of children and adolescents, but recognize the shortages of trained staff and limited options for referral to specialty care.[43] Other barriers to mental health services in schools are the current emphasis on educational mission, fear of infringement on family rights, insufficient funding and general discomfort about addressing issues of mental health.[44]

Promote Integrated Community Initiatives

Many of the most thoroughly researched, evidenced-based programs in the mental health arena relate to suicide prevention and provide an example with potential broader applications.



Preventive interventions for suicide must be comprehensive and intensive if they are to have lasting effects. While an adolescent's suicide may be related to an underlying psychiatric disorder, other factors or risk behaviors come into play, such as co-occurring substance abuse, an eating disorder, a homicide or adverse life experiences.[45] Programs, school-based or otherwise, are more likely to be successful if they are designed to address suicide and suicidal behavior as part of a broader focus on mental health, coping skills in response to stress, substance abuse and aggressive behaviors.[46]

The key components of a successful suicide prevention program depend upon linking intervention opportunities with service-oriented programs that are available in a range of settings.

Establish Programs that Promote Healthy Social Skills and Relationships

One way to promote mental health is by ensuring that young people have skills and relationships that provide them a good foundation for dealing with life's stressors.

Along with the physical and cognitive changes of adolescence, relationships with parents and peers change too. Relationships of high quality have a beneficial impact on psychological health.

Child Trends, a non-profit, non partisan research organization, carried out a review of more than 360 research studies that relate to social competency in adolescence. Social competence is defined as "the ability to achieve personal goals in social interaction, while at the same time maintaining positive relationships with others over time and across situations."[47] Only programs proven through research were included in the review of "what works". Effective programs were found to influence a number of social competency dimensions.

- Good parent-child relationships appear to influence the quality of other relationships, such as friends and romantic partners, and also affect adolescents' psychological and psychosocial development. Programs designed to develop teens' social skills and mentoring programs can boost the quality of the parent-adolescent relationship.
- Non-parental adults, especially grandparents, can serve as role models, teachers and supporters to teens by providing information about family history and culture. A program to help people become better grandparents is promising.

- Teens who have friendships with adults outside their families get along better with their parents. Successful mentoring programs match teens with adults based on similar interests, structure meetings at regular times, offer social activities, ensure that the programs are youth-driven and responsive, maintain long-term relationships and train participants before and during the program.

Support Treatment Approaches that Improve Mental and Emotional Health

Our culture often portrays teens as moody, dramatic and difficult. However, some have serious mental and emotional problems that go beyond this common stereotype. Policymakers should be aware of the harmful consequences of these conditions, and develop sound prevention and intervention strategies to address these challenges.

Child Trends also carried out a review of more that 300 research studies on teens' mental health and emotional well-being.[48] The review contains a number of recommendations that could improve mental health programs targeting this age group:

- Programs that use comprehensive, integrated approaches appear to be most effective in preventing such problems as conduct disorder, attention deficit and hyperactivity disorder and drug and alcohol abuse.
- Approaches that work to change a person's thoughts in order to change a behavioral and emotional state (also known as cognitive-behavioral therapy), drug therapy and environmental strategies appear to reduce mental health disorders, including depression and anxiety.
- Early prevention programs may head off a number of mental and behavioral health problems in adolescents.

Suicide Prevention and Intervention Best Practices

- Provide outreach to young people at risk of committing suicide. Develop screening, assessment and referral programs in primary care health settings and schools. Strengthen the connections between these settings and mental health services so that youth who need mental health services can receive timely assistance.
- Educate professionals and other adults in "gatekeeper" positions to recognize youth exhibiting suicidal behaviors. Train these adults to identify the warning signs of suicide and how to respond appropriately.
- Provide mental health services to youth and families in need. Telephone crisis lines need to be available to assist youth in a suicide crisis. Mental health services should be available and provided by professionals skilled in adolescent mental health issues. Suicide support services need to be available for families and loved ones.

Warning Signs of Suicide

Four out of five teens who attempt suicide give clear warnings. Pay attention to these warning signs:

- Suicide threats, direct and indirect
- Obsession with death
- Poems, essays and drawings that refer to death
- Dramatic change in personality or appearance
- Irrational, bizarre behavior
- Overwhelming sense of guilt shame or reflection
- Changed eating or sleeping patterns
- Severe drop in school performance
- Giving away belongings

Tennessee Mental Health Prevention Programs

Tennessee Suicide Prevention Network (TSPN)

The Tennessee Suicide Prevention Network is the statewide organization responsible for implementing the Tennessee Strategy for Suicide Prevention, as defined by the 1999 Surgeon General's Call to Action to Prevent Suicide. TSPN consists of a grassroots team of

Helping Suicidal Youth and Young Adults

Offer help and listen.

- Encourage depressed teens to talk about their feelings. Listen, don't lecture.
- Trust your instincts. If it seems that the situation may be serious, seek prompt help. Break a confidence, if necessary, in order to save a life.
- Pay attention to talk about suicide. Ask direct questions and don't be afraid of frank discussions. Silence is deadly!
- Seek professional help. It is essential to seek expert advice from a mental health professional that has experience helping depressed teens. Also, alert key adults in the teen's life family, friends and teacher.[49]

Tennesseans, divided into 8 regions under the direction of the Statewide Suicide Prevention Network Executive Director. The goals of TSPN are to work towards the elimination of the stigma of suicide, to educate the community about the warning signs of suicide, and ultimately to reduce the rate of suicide in the state of Tennessee. For more information, access their website at www.tspn.org.

Jason Foundation

The Jason Foundation, Inc. is a nationally recognized leader in youth suicide awareness, education and prevention. The foundation provides information, education programs and resources to parents, educators, youth and others who want to help in the fight against the *"silent epidemic"* of youth suicide. Project Tennessee, the Jason Foundation school-based curriculum, is in 800 middle and high schools in Tennessee. Approximately, 190,000 students were served through Project Tennessee in 2003-2004. Also, 2,114 teachers attended school in-service trainings, 2,460 youth attended seminars held at community centers, churches and other community sites and 2,400 parents and other adults attended educational seminars during this same time period.[50]

System of Care

Increasingly over the past six years, the concept and philosophy of a "system of care" has provided an organizing framework for system reform in Tennessee's mental health delivery system for children and youth. System of care is defined as a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families.[51]

The core values of the system of care philosophy specify that services should be community based, child centered and family focused, and culturally competent, and the guiding principles specify that services should be:

- Comprehensive, with a broad array of services;
- Individualized to each child and family;
- Provided in the least restrictive, appropriate setting;
- Coordinated both at the system and service delivery levels;
- Involve families and youth as full partners; and
- Emphasize early identification and intervention.

The system of care concept recognizes that children and families have needs in many domains and promotes a holistic approach in which all life domains and needs are considered.[52]

Nashville Connection System of Care Project for Children With Serious Emotional Disturbances

The Nashville Connection was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice to establish a system of care in Nashville, Tennessee, for children with serious emotional disturbances. The project has been active for the past six years and focuses on preventing children at imminent risk of being removed from their homes and placed either in state custody and/or some kind of institution. Nontraditional wraparound services needed to keep children at home are provided by case-managers. Evaluation results show that the children involved with this project showed clinical improvement over time, the number of episodes of residential care declined, the

number of children with failing school performances decreased, school absenteeism decreased and caregivers reported better coordinated service delivery.[53] For more information, access their website at www.tnvoices.org.

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